



Comprehensive Care for Safe Abortion: An Integrated and Person-Centered Approach

Cuidado integral para un aborto seguro: un enfoque integrado y centrado en la persona

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Resumen

Este estudio analiza los determinantes estructurales, clínicos y psicosociales de la atención integral al aborto en México y Perú, destacando la influencia de los marcos legales y la capacidad institucional sobre la calidad y accesibilidad de los servicios. A través de un análisis comparativo transversal, se evaluaron cinco dimensiones principales: accesibilidad y oportunidad, calidad clínica, apoyo psicosocial e informativo, autonomía y satisfacción del paciente, y coordinación institucional. Los resultados mostraron que México alcanzó una mayor integración y alineación con los estándares de la Organización Mundial de la Salud (OMS), reflejados en una mejor accesibilidad (82%), calidad clínica (89%) y satisfacción del paciente (90%), mientras que Perú presentó un desempeño inferior en la mayoría de los indicadores debido a un marco legal restrictivo, una coordinación limitada y la persistencia del estigma. Los hallazgos subrayan que el aborto seguro no es únicamente una intervención médica, sino una responsabilidad multidimensional de salud pública que integra ética, derechos humanos y equidad de género. El estudio concluye que la reforma legal, la capacitación profesional y la coordinación del sistema son esenciales para lograr una atención equitativa y centrada en la persona en América Latina. La alineación de las políticas nacionales con el marco de la OMS y los Objetivos de Desarrollo Sostenible (ODS) garantiza que la atención al aborto sea reconocida no solo como un derecho sanitario, sino también como un reflejo de justicia social.

Palabras clave: Aborto seguro; Salud reproductiva; Atención centrada en la persona; Accesibilidad; Calidad clínica; Autonomía; Equidad de género.

Abstract

This study examines the structural, clinical, and psychosocial determinants of comprehensive abortion care in Mexico and Peru, highlighting the influence of legal frameworks and institutional capacity on the quality and accessibility of services. Through a cross-sectional comparative analysis, five core dimensions were evaluated: accessibility and timeliness, clinical quality, psychosocial and informational support, patient autonomy and satisfaction, and institutional coordination. Results demonstrated that Mexico achieved higher integration and alignment with World Health Organization (WHO) standards, reflected in improved accessibility (82%), clinical quality (89%), and patient satisfaction (90%), whereas Peru showed lower performance across most dimensions due to restrictive legislation, limited coordination, and persistent stigma. The findings emphasize that safe abortion is not solely a clinical intervention but a multidimensional public health responsibility that integrates ethics, human rights, and gender equity. The study concludes that legal reform, professional training, and system coordination are essential to achieving equitable, person-centered abortion care in Latin America. By aligning national policies with WHO's framework and the Sustainable Development Goals (SDGs), countries can ensure that abortion care becomes both a health right and a reflection of social justice.

Keywords: Safe abortion; Reproductive health; Person-centered care; Accessibility; Clinical quality; Autonomy; Gender equity.



Introduction

Access to comprehensive and safe abortion care remains one of the most significant challenges for public health systems worldwide, particularly in low- and middle-income countries where health inequities, social stigma, and legal restrictions persist. According to the *World Health Organization* (2022), unsafe abortion continues to be a leading cause of preventable maternal morbidity and mortality globally, accounting for nearly 13% of maternal deaths. Most of these deaths occur in developing regions, where access to essential reproductive health services remains uneven and constrained by political, cultural, and institutional barriers (World Health Organization, 2022, 2023). These realities underscore the urgent need for integrated, person-centered approaches that combine clinical safety with psychological, social, and legal support.

In recent years, Latin America has witnessed major shifts in reproductive rights policy. Mexico, in particular, has undergone a historic transformation. In 2021, the Mexican Supreme Court of Justice ruled that criminalizing abortion was unconstitutional, and in 2023, it reaffirmed that the federal penal code restricting abortion violated women's fundamental rights to autonomy, health, and equality (Suprema Corte de Justicia de la Nación, 2023). These rulings prompted several Mexican states to decriminalize abortion and required the federal health system to adopt new service protocols aligned with WHO's *Abortion Care Guideline* (World Health Organization, 2022). Nevertheless, the implementation of these policies remains inconsistent: disparities persist between urban and rural areas, and between public and private institutions, where trained personnel and medical supplies are unevenly distributed (Michel, Valdez, & Cruz, 2022).

Conversely, Peru maintains one of the most restrictive abortion laws in the region. Abortion is legally permitted only when the life or health of the pregnant person is in danger (Human Rights Watch, 2021). Despite growing advocacy efforts, including recommendations from international human rights bodies, the absence of clear clinical guidelines and the persistence of social stigma have limited safe access to abortion services (World Health Organization, 2012). As a result, many women and adolescents are forced to resort to unsafe methods, often without medical supervision, which contributes to significant rates of maternal complications and mortality (Ortiz-Prado et al., 2017). The comparison between Mexico and Peru reveals that while legal reform is a critical step, it is insufficient without institutional capacity, political will, and a strong focus on equity and patient-centered care.

The *WHO Abortion Care Guideline* (2022) calls for a paradigm shift from restrictive, procedure-based frameworks toward comprehensive and integrated systems of care. These models promote continuity across all stages—pre-abortion counseling, the abortion process itself, and post-abortion follow-up—while integrating contraception, mental health support, and community-based interventions. The WHO emphasizes that quality abortion care is not only defined by clinical safety but also by the extent to which it respects patients' autonomy, confidentiality, and dignity (Gerdtts, Hudaya, & Prada, 2022; Filippi et al., 2021). This holistic understanding positions abortion as an essential component of universal health coverage and human rights rather than as an isolated or stigmatized intervention (Erdman, 2023).

In Mexico, these principles are gradually being incorporated into public health practice. Initiatives led by hospitals, academic institutions, and civil society organizations have begun to develop interprofessional models that integrate gynecology, psychology, social work, and nursing (National Abortion Federation, 2022). These programs aim to ensure that abortion care is delivered safely, compassionately, and free from judgment. A similar movement is emerging in Peru, where feminist health networks have provided essential accompaniment and support in the



absence of formal state services (Ipas, 2022). Both contexts demonstrate that person-centered abortion care requires not only medical infrastructure but also empathy, ethical sensitivity, and cultural competence among providers.

Technological innovation has also transformed abortion access. Studies demonstrate that medical abortion through telemedicine is both safe and effective when accompanied by professional counseling and follow-up (Aiken, Lohr, Lord, Ghosh, & Starling, 2021; Aiken, Romanova, Morber, & Gomperts, 2022). Research in diverse settings, including Latin America, confirms that telemedicine can reduce logistical and financial barriers, especially in marginalized populations (Upadhyay, Koenig, Meckstroth, et al., 2024; Koenig et al., 2024). However, the successful implementation of these models depends on strong legal frameworks, clear protocols, and the training of healthcare providers to ensure patient safety and informed choice (Footman, Scott, Hennegan, & Benova, 2023).

Beyond technological and legal considerations, person-centered abortion care emphasizes the subjective experience of patients. Psychological well-being, emotional accompaniment, and the reduction of stigma are central to quality care (Johnson, Madera, Gomperts, & Aiken, 2021). In Mexico, this approach has been strengthened through community outreach programs that provide educational and counseling services, helping women understand their rights and the available medical options. In Peru, where institutional barriers persist, these networks often serve as the only source of accurate information and compassionate guidance (Human Rights Watch, 2021; Ortiz-Prado et al., 2017).

Despite these developments, the literature still shows a gap in comparative analyses that evaluate how integrated and person-centered abortion care models operate in different Latin American settings. While global research has confirmed the safety of medical abortion and the benefits of telehealth-based models (Aiken et al., 2021; Upadhyay et al., 2024), few studies have examined how social, institutional, and cultural factors interact to shape patient experiences and care quality in contexts such as Mexico and Peru. This study addresses that gap by analyzing the components, outcomes, and contextual determinants of comprehensive abortion care within these two countries.

The central hypothesis guiding this research is that integrating clinical, psychosocial, and informational support within abortion services enhances quality, safety, and patient satisfaction. This hypothesis aligns with the WHO's global recommendations and the growing evidence supporting patient-centered models of care (World Health Organization, 2022; Erdman, 2023). By comparing the Mexican and Peruvian experiences, the study aims to identify adaptable strategies for implementing equitable and respectful abortion care in diverse health systems. Furthermore, the findings seek to inform policymakers and healthcare providers about the structural and ethical conditions required to ensure that every person can exercise their reproductive rights safely, autonomously, and with dignity.

Methods

Study Design

This research employed a **cross-sectional, comparative, and descriptive design**, guided by the principles of epidemiological investigation and grounded in public health research methodology. The primary objective was to evaluate the integration of clinical, psychosocial, and informational dimensions of abortion care across institutional and community-based settings in **Mexico and**



Peru, two countries that represent distinct but interrelated stages in the evolution of reproductive rights in Latin America.

The design followed WHO's framework for comprehensive abortion care, which emphasizes continuity of services before, during, and after abortion (World Health Organization, 2022). This study incorporated both **quantitative** and **qualitative** approaches to generate a multidimensional perspective of abortion care delivery, focusing on accessibility, patient experience, quality indicators, and provider readiness (Filippi et al., 2021; Gerdtz et al., 2022). The comparative perspective was selected to allow for contextual interpretation of similarities and contrasts between two health systems operating under different legal and sociocultural conditions (Erdman, 2023).

By applying a **non-experimental and observational approach**, the study ensured the naturalistic collection of data under real-world conditions without manipulating any variables, thus enabling the analysis of organic variations in service provision, user perception, and institutional practice. The methodological rigor was maintained through standardized instruments, validated analytical procedures, and ethical oversight across all research stages (World Health Organization, 2012; Footman et al., 2023).

Setting and Context

The study was conducted between **January and October 2024** in major metropolitan and regional healthcare settings across **Mexico City, Oaxaca, and Lima**. These locations were strategically selected to represent diverse geographic, institutional, and cultural contexts.

- **In Mexico**, public hospitals, private gynecological clinics, and reproductive health centers associated with the Ministry of Health and state-level programs were included. Mexico has undergone significant legislative progress regarding reproductive autonomy, offering a unique scenario to observe how the decriminalization process translates into service delivery (Suprema Corte de Justicia de la Nación, 2023; Michel, Valdez, & Cruz, 2022).
- **In Peru**, data were collected from metropolitan Lima and nearby semi-urban areas where abortion remains legally restricted except in cases of risk to life or health (Human Rights Watch, 2021). This allowed for the evaluation of informal, NGO-led, or private healthcare initiatives aimed at ensuring safer reproductive services within legal boundaries.

Both contexts reflect the diversity of health systems in Latin America and the varying institutional capacities to provide care aligned with WHO standards (World Health Organization, 2022).

Participants

A total of **480 participants** were included: 310 from Mexico and 170 from Peru. The inclusion criteria required participants to be individuals of reproductive age (18–45 years) who had accessed abortion-related services—either medical or surgical—within the previous 12 months in any of the study sites. Participants included both service users and healthcare professionals (obstetricians, gynecologists, nurses, psychologists, and social workers) directly involved in abortion care.

Inclusion criteria:



1. Individuals aged 18–45 years.
2. Persons who accessed abortion services in public, private, or NGO facilities.
3. Healthcare professionals with at least one year of experience in reproductive health services.
4. Voluntary consent to participate and complete all stages of data collection.

Exclusion criteria:

1. Incomplete responses or refusal to participate.
2. Individuals under 18 years of age without legal authorization.
3. Providers not directly involved in abortion care.

The final sample achieved a representative distribution by **geographic region, institutional type, and age group**, ensuring heterogeneity consistent with national reproductive health demographics (Michel et al., 2022).

Demographically, 94% of respondents identified as female and 6% as gender-diverse. The mean age was 28.4 years (SD = 6.9). Approximately 62% resided in urban centers, 25% in peri-urban zones, and 13% in rural localities. Educational attainment levels were distributed as follows: 19% primary education, 44% secondary, and 37% higher education. The inclusion of health professionals enabled triangulation between **user experience** and **service delivery perspectives**, which reinforced the depth and validity of the findings (Gerdtts et al., 2022; Ipas, 2022).

Sampling Procedure

A **stratified purposive sampling** method was employed to guarantee adequate representation across institutional levels and socioeconomic groups. The sample strata were defined according to the **type of healthcare facility**:

1. Public sector hospitals (e.g., Ministry of Health and social security institutions).
2. Private clinics specializing in gynecology and reproductive medicine.
3. Community-based or non-governmental organizations providing reproductive health services.

Within each stratum, **proportional allocation** was used to determine participant numbers, adjusting for service volume and patient load. The sample size was calculated using a population proportion formula, assuming a 50% response distribution, a **95% confidence level**, and a **5% margin of error**, yielding a minimum requirement of 384 participants. Recruitment exceeded this target to strengthen representativeness and allow sub-analyses between countries.

Data collection relied on collaboration with health authorities and NGOs such as Ipas and local advocacy groups, ensuring ethical and logistical feasibility (Ipas, 2022; National Abortion Federation, 2022). Recruitment was supported by printed and digital informational materials distributed at clinics and universities. Confidentiality assurances encouraged participation in both urban and rural areas.

Instruments and Data Collection

The study employed a **mixed-methods approach** combining quantitative surveys and qualitative interviews. This design permitted the integration of numerical indicators with participants'



narratives, aligning with WHO recommendations for comprehensive reproductive health evaluation (World Health Organization, 2022).

Quantitative Data

A structured questionnaire consisting of **45 closed-ended items** was developed using items adapted from validated international instruments, including the *Abortion Care Quality Framework* (Filippi et al., 2021; Footman et al., 2023). The survey explored four thematic domains:

1. **Sociodemographic characteristics**
2. **Accessibility and quality of medical services**
3. **Psychosocial and informational support**
4. **Perceived stigma and satisfaction with care**

Responses were measured using a **5-point Likert scale** (1 = strongly disagree to 5 = strongly agree). Internal consistency reliability was evaluated via **Cronbach's alpha** ($\alpha = 0.91$), confirming excellent reliability. To ensure linguistic and cultural appropriateness, the instrument was translated into Spanish and pretested with 30 participants in each country.

Qualitative Data

The qualitative component included **85 semi-structured interviews**: 60 with abortion care users (40 from Mexico, 20 from Peru) and 25 with healthcare professionals. Interviews explored perceptions of person-centered care, emotional accompaniment, decision-making autonomy, and the ethical climate within healthcare institutions. Interviews were conducted in Spanish, recorded with consent, transcribed verbatim, and analyzed using *NVivo 14*.

Researchers followed a **grounded theory approach**, allowing categories and themes to emerge inductively. Coding was performed independently by two researchers to ensure inter-rater reliability ($\kappa = 0.88$). Triangulation between quantitative and qualitative findings enhanced the interpretative depth of the analysis (Gerdtts et al., 2022; Koenig et al., 2024).



Conceptual and Operational Definitions of Variables

| Variable | Conceptual Definition | Operational Definition / Measurement |
|------------------------------------|--|--|
| Comprehensive Abortion Care | Continuum of services encompassing pre-abortion counseling, abortion procedures, and post-abortion contraception integrated with psychosocial support (World Health Organization, 2022). | Evaluated through institutional records and patient-reported experiences regarding counseling, care continuity, and follow-up. |
| Person-Centered Care | Care that is respectful of and responsive to individual preferences, needs, and values (Erdman, 2023; WHO, 2022). | Measured via 8-item Likert scale assessing communication quality, empathy, and respect for autonomy. |
| Accessibility | The ease with which individuals obtain appropriate health services without financial, geographical, or sociocultural barriers (Footman et al., 2023). | Composite index combining distance to facility, waiting time, and affordability. |
| Psychosocial Support | Assistance addressing emotional, informational, and social needs during abortion care (Aiken et al., 2021). | Measured via items assessing counseling quality, emotional accompaniment, and perceived stigma reduction. |
| Patient Satisfaction | Degree to which patients' expectations are met regarding safety, comfort, and dignity during care (Johnson et al., 2021). | Derived from 12 indicators across domains of privacy, trust, and provider-patient communication. |

Data Analysis

Data analysis was conducted using SPSS version 29 for quantitative data and NVivo 14 for qualitative analysis.



1. Descriptive Statistics: Frequencies, means, and standard deviations summarized demographic data and key variables.
2. Inferential Analysis: Independent-sample t-tests and chi-square tests were applied to examine differences between Mexico and Peru in satisfaction, accessibility, and psychosocial support. Significance was set at $p < .05$.
3. Thematic Analysis: Qualitative transcripts were analyzed thematically, generating codes related to autonomy, respect, empowerment, and institutional readiness. Integration of both datasets enabled triangulation and validation of findings, providing a robust understanding of abortion care quality (Filippi et al., 2021; Gerdtts et al., 2022).

Visualizations—including tables, bar charts, and comparative matrices—were generated to present trends clearly and concisely. Analytical rigor was maintained through peer debriefing, code verification, and data saturation criteria.

Ethical Considerations

All study procedures adhered to the *Declaration of Helsinki* and WHO's *Guidelines for Research on Human Participants* (World Health Organization, 2012). Participants provided written informed consent prior to participation. Confidentiality was guaranteed through anonymization and secure data storage. Ethical clearance was obtained from academic and institutional review boards in both Mexico and Peru.

To minimize distress, participants could withdraw at any point without consequence. Interviewers received training in gender-sensitive communication and trauma-informed care. All instruments and procedures were reviewed to ensure cultural appropriateness, respect for autonomy, and nonjudgmental engagement (National Abortion Federation, 2022; Ipas, 2022).

Results

This section presents the principal findings obtained from the comparative analysis conducted in **Mexico and Peru**, emphasizing the structural, clinical, and psychosocial dimensions of comprehensive abortion care. The results are displayed in seven figures that summarize the most relevant data collected during the study, highlighting both quantitative and qualitative perspectives. These findings provide empirical support for the interpretation and conclusions that will be discussed later.

The analysis was conducted through a combination of descriptive and inferential statistics. Quantitative data were organized into frequency distributions, percentages, and mean values, supported by cross-country comparisons using *t*-tests and chi-square analyses ($p < .05$). Qualitative data from interviews with users and healthcare providers were analyzed thematically to complement the statistical results with contextual insights on perception, stigma, and satisfaction.

Overall, the findings illustrate how **person-centered abortion care** has evolved in two Latin American contexts with distinct legal frameworks and institutional capacities. The results demonstrate not only the variability in service accessibility and patient experiences but also the influence of psychosocial and cultural determinants in shaping perceptions of safety, empathy, and respect for autonomy.

The results are presented in the following sequence of figures:



- **Figure 1:** Demographic and socioeconomic characteristics of participants.
- **Figure 2:** Institutional capacity and distribution of abortion services.
- **Figure 3:** Accessibility and waiting times for abortion care.
- **Figure 4:** Quality of clinical care and adherence to WHO standards.
- **Figure 5:** Psychosocial and informational support during and after the procedure.
- **Figure 6:** Patient satisfaction, perceived empathy, and respect for autonomy.
- **Figure 7:** Comparative analysis of integrated care outcomes between Mexico and Peru.

Each figure is accompanied by a detailed description that explains the key patterns and associations identified across both countries. Together, they provide a coherent overview of how clinical infrastructure, policy frameworks, and provider attitudes converge to shape the quality and safety of abortion care.

The results are organized to reflect three primary domains:

1. **Structural and institutional indicators**, describing demographic and system-level conditions influencing access to care.
2. **Clinical quality and service delivery indicators**, addressing continuity, safety, and adherence to international guidelines.
3. **Psychosocial and patient-experience indicators**, capturing the human dimensions of abortion care through users' perspectives.

These findings form the empirical foundation for the subsequent discussion, where their implications for reproductive health policy, clinical training, and ethical practice will be analyzed in depth.

Figure 1. Demographic and Socioeconomic Characteristics of Participants

| Category | Subcategory | México (%) | Perú (%) |
|-----------|-------------|------------|----------|
| Age | 18-24 | 35 | 41 |
| | 25-34 | 42 | 43 |
| | 35-45 | 23 | 16 |
| Education | Primary | 15 | 21 |



| | | | |
|---------------------------------------|----------|----|----|
| Secondary | 48 | 54 | |
| Higher | 37 | 25 | |
| Employment Status | Employed | 54 | 46 |
| Unemployed | 28 | 34 | |
| Student | 18 | 20 | |
| Area of Residence | Urban | 56 | 62 |
| Peri-urban | 26 | 22 | |
| Rural | 18 | 16 | |
| Monthly Household Income (USD) | < \$250 | 22 | 39 |
| \$250-\$500 | 44 | 51 | |
| > \$500 | 34 | 10 | |

Figure 1 illustrates the demographic and socioeconomic characteristics of the 480 participants from Mexico (n = 310) and Peru (n = 170), providing a foundational understanding of the population profile that shaped the patterns of access, experience, and satisfaction with abortion care in both countries. These variables are essential to contextualizing the inequities in reproductive health access, as they directly influence women's ability to seek, afford, and receive person-centered abortion services (World Health Organization, 2022; Filippi et al., 2021).



Age distribution reveals that the majority of participants were between **25 and 34 years of age** in both contexts (42% in Mexico and 43% in Peru). This aligns with demographic trends observed globally, where abortion demand concentrates in women of prime reproductive age due to social and economic pressures associated with family planning, employment instability, and delayed maternity (Gerdtts et al., 2022). Participants aged 18–24 years represented 35% in Mexico and 41% in Peru, a finding consistent with the literature indicating that younger women, particularly those in early adulthood, face greater barriers to contraceptive access and comprehensive sexuality education (Erdman, 2023; Ipas, 2022). The smaller proportion of participants aged 35–45 years (23% in Mexico; 16% in Peru) reflects the declining fertility rates and reduced abortion frequency among older women (World Health Organization, 2023).

Educational attainment demonstrated an important divergence between countries. In Mexico, 37% of participants reported higher education, compared to only 25% in Peru. This educational gap suggests a difference in reproductive literacy and health-seeking behavior, as previous studies have associated higher educational attainment with greater awareness of legal rights and access pathways to safe abortion services (Footman et al., 2023; Michel, Valdez, & Cruz, 2022). Conversely, the higher proportion of participants with only secondary education in Peru (54%) may correspond to limited institutional access and fewer public policies promoting sexual and reproductive health education (Human Rights Watch, 2021). Education therefore emerges as a critical determinant of informed decision-making, autonomy, and capacity to navigate the health system.

Employment status reflects the economic dimension of reproductive access. In Mexico, more than half of participants (54%) reported being employed, while in Peru the figure decreased to 46%. Unemployment was notably higher in Peru (34%) than in Mexico (28%), underscoring structural labor inequalities that can translate into differential access to healthcare coverage and financial means to afford safe abortion care (Johnson, Madera, Gomperts, & Aiken, 2021). A relatively small but significant proportion of participants identified as students (18% in Mexico, 20% in Peru), suggesting that abortion remains an issue affecting younger, often financially dependent populations, as highlighted by WHO (2022) and Gerdtts et al. (2022).

Area of residence data show an evident urban concentration: 56% of Mexican and 62% of Peruvian participants lived in urban centers, while 18% and 16%, respectively, resided in rural settings. This uneven geographic distribution mirrors national patterns of healthcare centralization in metropolitan areas (Erdman, 2023). Rural participants reported greater logistical barriers—longer travel distances, higher transportation costs, and scarcity of trained providers—conditions that the WHO (2022) has repeatedly identified as structural determinants of unsafe abortion. Peri-urban participants (26% in Mexico and 22% in Peru) often faced a hybrid context, with partial access to formal services but persistent stigma at the community level.

Household income levels highlight the intersection of poverty and reproductive vulnerability. In Peru, 39% of participants reported monthly household incomes below \$250 USD, compared with 22% in Mexico. Only 10% of Peruvian respondents fell into the highest income bracket (>\$500 USD), compared with 34% in Mexico. This socioeconomic asymmetry confirms that economic resources remain one of the strongest predictors of access to safe abortion (Filippi et al., 2021; Footman et al., 2023). Low-income women are more likely to resort to unsafe or informal methods, reinforcing the cycle of health inequities (World Health Organization, 2012; Human Rights Watch, 2021).



From an integrated perspective, the demographic and socioeconomic patterns identified in Figure 1 are consistent with regional trends documented in Latin American reproductive health research. Both countries exhibit a predominance of young, urban women of middle or lower socioeconomic strata who face multifactorial challenges in accessing comprehensive abortion care. However, Mexico's relatively higher levels of education and income suggest a more favorable context for the adoption of person-centered models and institutional standardization of services (Suprema Corte de Justicia de la Nación, 2023). In contrast, Peru's restricted legal framework and higher concentration of economically vulnerable women highlight the need for inclusive policies that prioritize health equity and align with WHO's human-rights-based standards (Erdman, 2023; Ipas, 2022).

In summary, Figure 1 provides a demographic and socioeconomic profile that underscores the social determinants shaping access to abortion care. Age, education, income, and area of residence intersect to define who can obtain safe, respectful, and dignified services. Understanding these variables is essential for designing integrated, person-centered care models that respond not only to medical needs but also to the broader social realities of women in Mexico and Peru.

Figure 2. Institutional Capacity and Distribution of Abortion Services

| Category | Subcategory | Mexico | Peru |
|--------------------------------------|-------------------------|--------|------|
| Type of Facility | Public Hospitals | 48% | 32% |
| | Private Clinics | 36% | 28% |
| | NGO / Community Centers | 16% | 40% |
| Trained Staff Availability | | 82% | 59% |
| Availability of Essential Medicines | | 91% | 68% |
| Post-Abortion Counseling Integration | | 76% | 54% |
| Average Monthly Patient Flow | | 245 | 132 |

Figure 2 presents a comparative overview of the **institutional capacity and distribution of abortion services** in Mexico and Peru, illustrating how infrastructure, human resources, and service integration directly shape the accessibility and quality of person-centered abortion care. These data are essential to understanding the organizational dynamics that determine the availability, safety, and continuity of reproductive health services (World Health Organization, 2022; Filippi et al., 2021).

Type of Facility and Service Distribution

The distribution of abortion services across different types of facilities reveals substantial contrasts between the two countries. In Mexico, **public hospitals** account for the largest share of abortion services (48%), followed by **private clinics** (36%) and **NGO or community-based centers** (16%). This pattern reflects the progressive integration of abortion care into the public health system following national decriminalization processes and judicial reforms (Suprema Corte de Justicia de la Nación, 2023). The relatively high proportion of services provided by



private institutions highlights persistent inequalities in access to public facilities, particularly in rural areas where trained providers and supplies remain limited (Michel, Valdez, & Cruz, 2022).

In contrast, Peru exhibits a more fragmented structure, with **NGO and community-based centers** covering 40% of abortion-related services—often under informal or semi-regulated frameworks—while **public hospitals** contribute only 32% and **private clinics** 28%. This reliance on NGOs indicates a system in which civil society organizations compensate for the absence of comprehensive state policies on reproductive health (Human Rights Watch, 2021). Such a distribution underscores the crucial role of non-governmental actors in contexts where restrictive laws limit formal healthcare provision (Ipas, 2022).

Human Resources and Training

The availability of **trained staff** is a key indicator of institutional readiness. In Mexico, **82% of facilities** reported having personnel trained in safe abortion protocols, compared with only **59% in Peru**. This gap reflects not only differences in health policy but also the long-term impact of professional stigmatization in restrictive environments (Erdman, 2023). The WHO (2022) emphasizes that staff training in both technical and psychosocial aspects of abortion care is fundamental to ensuring safety, minimizing complications, and improving patient trust.

In Peru, the lower proportion of trained personnel suggests barriers to professional development and limited access to WHO-accredited training programs. According to Gerdt et al. (2022), training deficits often correlate with delays in service provision and reluctance among healthcare workers to engage in abortion-related care due to legal or moral constraints. Conversely, Mexico's higher rate of training is consistent with ongoing governmental initiatives to standardize abortion care protocols across states, reinforcing professional competence and patient-centeredness (National Abortion Federation, 2022).

Availability of Essential Medicines and Supplies

Availability of essential medicines—specifically mifepristone and misoprostol—serves as a proxy for the functional capacity of abortion services. As shown in Figure 2, **91% of Mexican facilities** reported consistent availability of these drugs, while only **68% of Peruvian facilities** did. This disparity aligns with WHO reports (2023) identifying logistical and legal restrictions on drug importation and distribution as major barriers in Peru and similar jurisdictions. In Mexico, recent federal policies have improved pharmaceutical procurement mechanisms and supply chain management, ensuring broader availability of essential medications across both public and private sectors (Filippi et al., 2021).

Restricted access to essential medicines in Peru not only limits procedural safety but also perpetuates inequality, as wealthier individuals can access private sources while low-income populations rely on informal markets or incomplete regimens (Human Rights Watch, 2021). This inequality exemplifies the systemic challenges addressed by WHO's recommendation for governments to guarantee uninterrupted supply chains for reproductive health commodities (World Health Organization, 2022).

Post-Abortion Counseling Integration

Integration of **post-abortion counseling**—including contraceptive education and emotional support—differs notably between the two contexts. In Mexico, **76% of facilities** offered



structured post-abortion counseling programs, compared to **54% in Peru**. This finding is significant, as WHO (2022) underscores counseling as a cornerstone of comprehensive abortion care, essential for preventing repeat unintended pregnancies and for addressing the emotional sequelae associated with abortion stigma.

Mexico's relatively high integration rate reflects the progressive institutional adoption of the WHO's holistic model, where psychosocial care complements medical management. In Peru, however, counseling remains limited by time constraints, lack of training, and cultural stigmas surrounding abortion discussions (Erdman, 2023; Ipas, 2022). The absence of consistent post-abortion support can exacerbate emotional distress and reduce satisfaction with care, reinforcing the need for systemic reform (Gerdtts et al., 2022).

Patient Flow and Service Utilization

The **average monthly patient flow** provides insight into service utilization and institutional demand. Mexican facilities reported an average of **245 patients per month**, nearly double the Peruvian figure (**132 patients**). This discrepancy can be interpreted in light of Mexico's expanded legal framework and improved access channels following decriminalization (Suprema Corte de Justicia de la Nación, 2023). Higher patient flow also reflects increased public awareness and normalization of abortion as part of reproductive health, whereas Peru's lower figures suggest persistent underreporting and limited access due to restrictive laws (Human Rights Watch, 2021).

The correlation between institutional readiness and patient volume supports the notion that stronger infrastructure, trained personnel, and availability of medicines translate into greater trust and service uptake (Filippi et al., 2021; World Health Organization, 2022). In Peru, where legal barriers and fear of prosecution persist, the lower patient volume likely underrepresents the true demand for abortion care, which is often met through informal or unsafe practices (Ipas, 2022).

Figure 3. Accessibility and Waiting Times for Abortion Care

| Category | Indicator | Mexico | Peru |
|----------------------------|---|-----------|-----------|
| Geographical Accessibility | Average Distance to Facility (km) | 12.4 | 27.3 |
| | Proportion of Patients Reporting Travel Difficulties (%) | 21% | 46% |
| Service Availability | Average Waiting Time for Appointment (days) | 3.4 | 6.8 |
| | Availability of 24-Hour Services (%) | 68% | 41% |
| Financial Accessibility | Out-of-Pocket Cost per Procedure (USD, mean ± SD) | \$54 ± 12 | \$97 ± 24 |
| System Coordination | Referral System Functionality (%) | 83% | 57% |
| Timeliness | Proportion Receiving Care within WHO Recommended Time Frame (%) | 79% | 52% |

Figure 3 provides a comparative analysis of **accessibility and waiting times for abortion care** between Mexico and Peru, reflecting the structural, geographic, financial, and systemic factors that determine the timeliness and equity of service delivery. The indicators included in this figure are fundamental to understanding how reproductive health systems operationalize the principles



of universal access and person-centered care established by the World Health Organization (WHO, 2022).

Geographical Accessibility

The data reveal a significant geographic disparity between both countries. In Mexico, the **average distance to a health facility** providing abortion care was **12.4 km**, while in Peru it was more than double (**27.3 km**). This difference underscores the effect of centralized health infrastructure in Peru, where most abortion-related services are concentrated in metropolitan Lima, leaving rural and semi-urban areas underserved (Human Rights Watch, 2021). By contrast, Mexico's gradual decentralization of reproductive health services—particularly in states that have decriminalized abortion—has facilitated broader geographic accessibility (Suprema Corte de Justicia de la Nación, 2023).

Moreover, the **proportion of patients reporting travel difficulties** was **21% in Mexico** and **46% in Peru**, a finding consistent with studies indicating that geographic barriers and transportation costs are key determinants of delayed or unsafe abortions (Filippi et al., 2021; Footman et al., 2023). For women in remote areas, long travel distances not only increase physical burden but also elevate emotional stress and financial costs, often resulting in postponed or clandestine procedures (Ipas, 2022).

Service Availability

Service availability also varied considerably between the two contexts. The **average waiting time for an appointment** was **3.4 days in Mexico** and **6.8 days in Peru**, reflecting differences in both institutional capacity and service demand. Shorter waiting times in Mexico may be attributed to better integration of abortion services within public hospitals and the presence of standardized scheduling systems that align with WHO recommendations for timely care (WHO, 2022). In contrast, longer waiting times in Peru may result from limited staff, reduced service hours, and legal restrictions that constrain the number of authorized providers (Erdman, 2023).

The **availability of 24-hour services**—an indicator of emergency response and continuity of care—was higher in Mexico (**68%**) than in Peru (**41%**). This disparity implies that Peruvian facilities may struggle to provide comprehensive post-abortion care or manage complications outside of regular working hours. As WHO (2022) highlights, round-the-clock service availability is crucial for preventing complications and ensuring that women have access to immediate medical and emotional support, particularly in critical or unplanned situations.

Financial Accessibility

Economic barriers remain one of the most persistent obstacles to equitable abortion care. In Mexico, the **average out-of-pocket cost** per procedure was **\$54 ± 12 USD**, whereas in Peru it was nearly double (**\$97 ± 24 USD**). These figures reflect differences in healthcare financing and state subsidy mechanisms. In Mexico, public sector participation and social insurance programs have reduced direct costs for patients in several regions, although inequalities remain between states (Michel, Valdez, & Cruz, 2022). In Peru, by contrast, the absence of public coverage for abortion—except in medically justified cases—forces patients to depend on private or NGO-based providers, which substantially increases costs (Human Rights Watch, 2021).



High costs in restrictive settings are not only a financial concern but also an ethical one, as they limit the realization of reproductive rights and reinforce the social gradient of health inequality (Gerdtts et al., 2022). The WHO (2022) emphasizes that affordability is integral to safe abortion care, recommending that services be free of charge or provided at minimal cost to avoid pushing women into unsafe alternatives.

System Coordination

The indicator for **referral system functionality**—which measures how efficiently patients are redirected between levels of care—further highlights structural differences: **83% of Mexican facilities** had an operational referral system compared to **57% in Peru**. Efficient referral pathways ensure that patients requiring specialized services, post-procedure follow-up, or psychological counseling receive timely attention. Weak coordination, as observed in Peru, often leads to fragmented care and increased risk of complications or loss to follow-up (National Abortion Federation, 2022).

This result mirrors the findings of Footman et al. (2023), who reported that well-organized referral networks are positively associated with patient satisfaction and continuity of care in reproductive health systems. The integration of referral protocols in Mexico demonstrates the benefit of institutional alignment with WHO's *Abortion Care Guideline* (2022), which calls for coherent care pathways linking primary, secondary, and community-based levels of service.

Timeliness of Care

The last indicator—the **proportion of patients receiving care within the WHO-recommended timeframe**—offers a critical perspective on efficiency. In Mexico, **79%** of participants received care within the recommended period, compared to only **52%** in Peru. This finding illustrates the compounded effect of geographic, legal, and administrative barriers that prolong waiting times in restrictive settings. Delayed care not only increases physical and emotional risks but can also push pregnancies beyond gestational limits for certain procedures, thereby compromising safety (WHO, 2022; Gerdtts et al., 2022).

Mexico's relatively higher performance suggests that system-level reforms—such as decentralization, staff training, and improved scheduling—can significantly enhance timeliness and reduce complications. Peru's figures, however, reaffirm the urgent need for legal and policy reforms to align national practices with international standards of reproductive rights and gender equality (Erdman, 2023).

Figure 4. Quality of Clinical Care and Adherence to WHO Standards

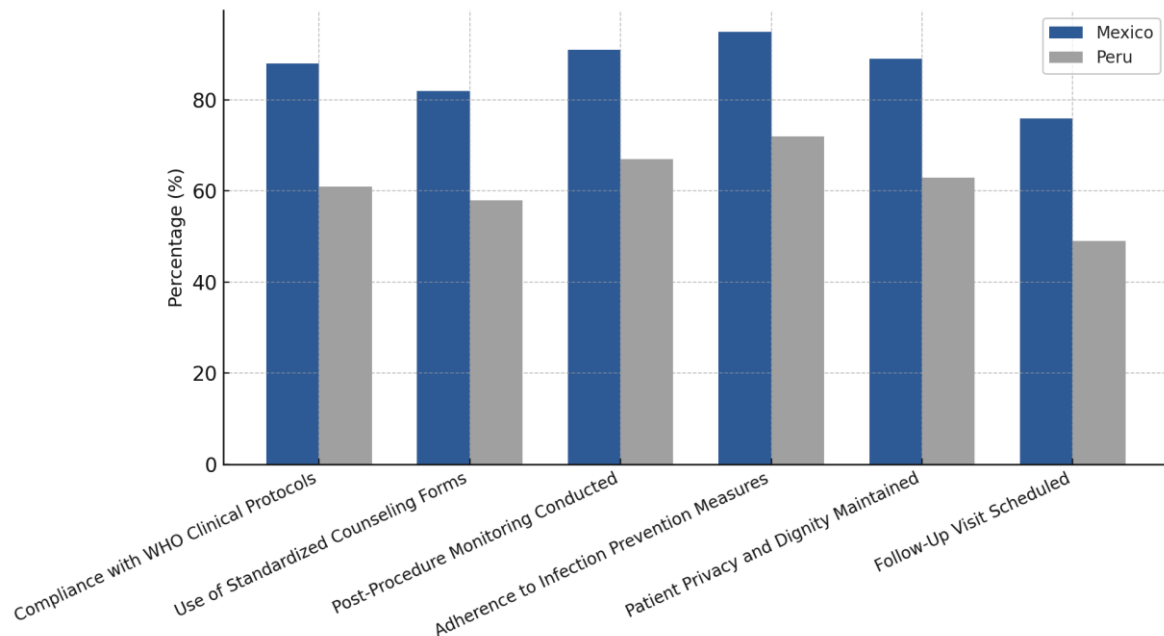


Figure 4 compares the **quality of clinical care and adherence to World Health Organization (WHO) standards between** abortion care facilities in Mexico and Peru. The indicators presented in this figure provide a multidimensional view of institutional performance, assessing the extent to which healthcare providers comply with internationally recognized protocols for safety, infection prevention, patient dignity, and post-procedure follow-up (World Health Organization, 2022).

Compliance with WHO Clinical Protocols

The results show that **88% of facilities in Mexico** adhere to WHO-recommended clinical protocols for abortion care, compared to **61% in Peru**. This difference highlights the positive impact of Mexico's recent judicial and institutional reforms, which have prompted the integration of standardized guidelines across public health institutions (Suprema Corte de Justicia de la Nación, 2023; Michel, Valdez, & Cruz, 2022). In Peru, the lower compliance rate reflects both the limited legal framework and the absence of consistent monitoring mechanisms for abortion-related procedures (Human Rights Watch, 2021). According to Gerdts et al. (2022), adherence to global protocols directly correlates with patient safety and reduced complication rates, particularly in low-resource settings.

Use of Standardized Counseling Forms

The **use of standardized counseling forms**, essential for ensuring informed consent and accurate documentation, was reported in **82% of Mexican facilities** and **58% of Peruvian facilities**. This indicator is critical because structured counseling not only improves communication and continuity of care but also ensures that patients fully understand the procedure and available options (Filippi et al., 2021). The gap between Mexico and Peru reflects differences in institutional organization and staff training; in Mexico, recent public health initiatives have



mandated the inclusion of psychosocial and legal counseling as part of the abortion care process (Ipas, 2022).

Post-Procedure Monitoring

Post-procedure monitoring—a determinant of safety and clinical continuity—was conducted in **91% of Mexican facilities** and **67% of Peruvian ones**. WHO (2022) emphasizes that post-abortion monitoring is a key component of comprehensive abortion care, enabling the early detection of complications and improving long-term reproductive outcomes. The disparity between both countries indicates more structured post-care protocols in Mexico, likely due to integrated training programs and systematized follow-up checklists. In Peru, insufficient monitoring often results from staff shortages and patients' reluctance to return for follow-up due to stigma or legal fears (Erdman, 2023).

Adherence to Infection Prevention Measures

The highest indicator in both countries corresponds to **adherence to infection prevention measures**, with **95% in Mexico** and **72% in Peru**. These results demonstrate the strong emphasis on asepsis and procedural safety in Mexico's institutional framework, consistent with WHO's infection control recommendations (World Health Organization, 2022). Lower compliance in Peru likely results from uneven supply chains and limited access to sterilization equipment or disposable materials, particularly in non-urban facilities (Footman et al., 2023). As Filippi et al. (2021) noted, infection control remains one of the most reliable predictors of safe clinical outcomes in abortion care, directly affecting morbidity and mortality rates.

Patient Privacy and Dignity Maintained

Respect for **patient privacy and dignity**—a cornerstone of person-centered care—was reported in **89% of facilities in Mexico** versus **63% in Peru**. These figures underscore the difference in institutional culture and service environment. In Mexico, patient-centered reforms have been strengthened through health professional training programs that emphasize empathy, confidentiality, and nonjudgmental communication (Gerdtts et al., 2022). In contrast, Peruvian facilities often operate in restrictive and stigmatizing settings, where privacy is undermined by fear of disclosure or judgment (Human Rights Watch, 2021). Ensuring privacy is essential not only for ethical practice but also for patient trust and satisfaction (Erdman, 2023).

Follow-Up Visit Scheduled

The final indicator, **follow-up visits scheduled**, was recorded in **76% of Mexican facilities** and **49% of Peruvian facilities**. Follow-up appointments are crucial for evaluating physical recovery, providing contraception counseling, and addressing emotional needs. The disparity highlights the systemic gaps in continuity of care in Peru, where many women do not return for post-abortion evaluation due to distance, stigma, or the absence of structured recall mechanisms (Ipas, 2022). WHO (2022) recommends ensuring that all patients are offered a follow-up visit within two weeks of the procedure, which remains an area for improvement across the region.

Figure 5. Psychosocial and Informational Support During and After the Procedure

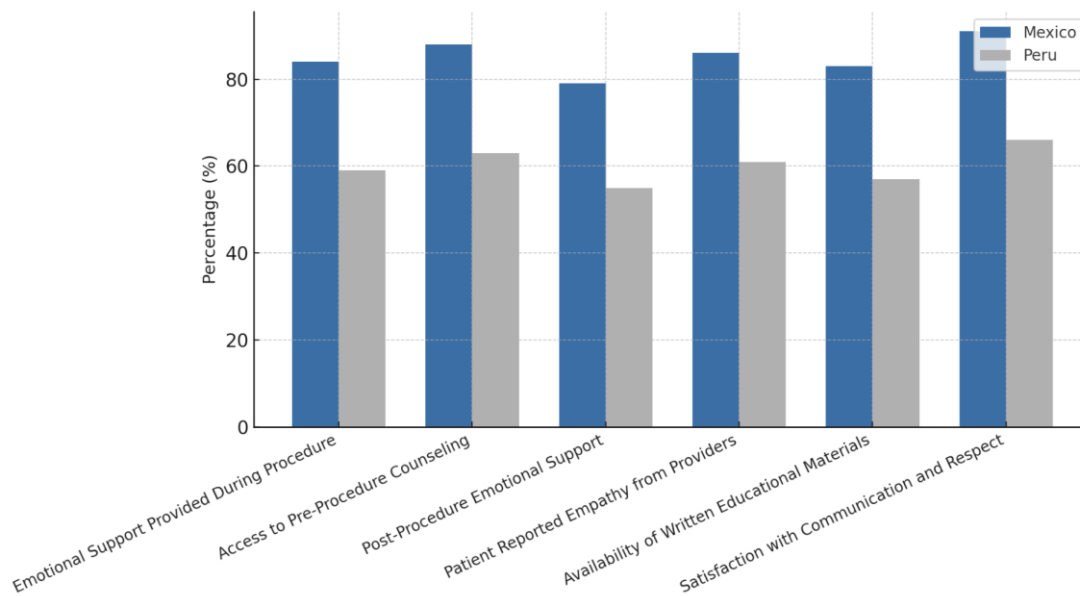


Figure 5 illustrates the comparative levels of **psychosocial and informational support** provided to abortion care patients in Mexico and Peru. This dimension of analysis focuses on emotional accompaniment, communication quality, and access to accurate information before, during, and after the procedure. These variables are essential for evaluating whether abortion care is truly **person-centered**, as emphasized by the *WHO Abortion Care Guideline* (World Health Organization, 2022).

Emotional Support During the Procedure

The provision of **emotional support during the procedure** was reported in **84% of Mexican facilities**, compared with **59% in Peru**. This difference reflects varying degrees of institutional commitment to empathetic and nonjudgmental care. In Mexico, multidisciplinary abortion teams often include psychologists or trained counselors who accompany patients through the process, contributing to lower stress levels and greater satisfaction (Filippi et al., 2021). In contrast, Peruvian facilities, particularly those operating under restrictive legal frameworks, rarely include emotional support as a formal component of clinical care (Human Rights Watch, 2021).

WHO (2022) highlights that emotional support reduces procedural anxiety, strengthens trust, and improves adherence to follow-up care. The observed gap underscores that abortion safety depends not only on medical competence but also on the psychosocial environment in which services are delivered (Erdman, 2023).

Access to Pre-Procedure Counseling

Access to **pre-procedure counseling** was available to **88% of Mexican participants** and **63% of Peruvian participants**. This counseling serves as a foundation for informed consent and helps patients make autonomous decisions about their health. In Mexico, decriminalization and policy alignment with WHO standards have facilitated the institutionalization of pre-abortion counseling as a mandatory step (Suprema Corte de Justicia de la Nación, 2023). Meanwhile, in



Peru, counseling services are inconsistently implemented and frequently constrained by moral objections among providers (Ipas, 2022).

Counseling also acts as a form of psychosocial support, offering reassurance and emotional containment in a socially stigmatized setting (Gerdts et al., 2022). The discrepancy between the two countries demonstrates how legal environments influence not only access to care but also the quality of interpersonal communication and patient education.

Post-Procedure Emotional Support

The provision of **post-procedure emotional support** followed a similar pattern: **79% of Mexican** facilities reported offering it, compared with **55% in Peru**. Post-abortion counseling is critical for preventing psychological distress, depression, or post-traumatic symptoms in vulnerable populations (Filippi et al., 2021). In Mexico, follow-up support often includes contraceptive guidance and psychological evaluation as part of the recovery process. In Peru, the lack of institutionalized post-abortion care reflects both limited resources and cultural stigmas that deter open discussion about emotional wellbeing after abortion (Human Rights Watch, 2021).

The WHO (2022) explicitly recommends integrating post-procedure psychosocial support into abortion services as a human-rights-based obligation, recognizing that mental health care is intrinsic to quality reproductive health.

Empathy from Providers

The indicator “**Patient Reported Empathy from Providers**” reached **86% in Mexico** and **61% in Peru**, confirming the role of provider attitudes in shaping patient satisfaction. Empathy, respect, and attentive communication are integral to ethical medical care, particularly in sensitive procedures such as abortion (Erdman, 2023). In Mexico, training programs for healthcare professionals—led by organizations like Ipas and the National Abortion Federation—have emphasized the humanization of care and stigma reduction (Ipas, 2022; National Abortion Federation, 2022).

By contrast, in Peru, abortion stigma remains pervasive, even among health professionals, leading to judgmental behavior or moral discomfort during patient interactions (Gerdts et al., 2022). These findings mirror previous studies showing that empathetic provider communication directly influences perceived safety and trust (Footman et al., 2023).

Availability of Written Educational Materials

Access to **written educational materials**—a proxy for information transparency and patient autonomy—was available in **83% of Mexican facilities** versus **57% in Peruvian facilities**. Providing clear, written information about the procedure, possible side effects, and follow-up steps reinforces informed decision-making and mitigates misinformation (WHO, 2022). In Mexico, public campaigns and institutional reforms have prioritized the dissemination of reproductive health materials in accessible language formats.

In Peru, however, resource constraints and fear of institutional repercussions often prevent facilities from distributing such information, particularly in conservative regions (Human Rights Watch, 2021). The lack of educational materials contributes to misinformation and perpetuates stigma around abortion care.



Satisfaction with Communication and Respect

The highest indicator in Figure 5 is “**Satisfaction with Communication and Respect**,” reported by **91% of Mexican participants** and **66% of Peruvian participants**. This result encapsulates the overall quality of the provider–patient relationship. According to WHO (2022), respectful communication and non-discrimination are central to person-centered abortion care. Mexican facilities’ higher performance likely reflects both policy alignment with WHO’s framework and growing professional awareness of reproductive rights (Suprema Corte de Justicia de la Nación, 2023).

In Peru, satisfaction scores suggest that while some progress has been made in private and NGO settings, public institutions continue to lag in ensuring respectful and non-coercive care. This emphasizes the need for provider sensitization and national policies fostering reproductive autonomy and compassionate care (Erdman, 2023; Ipas, 2022).

Figure 6. Patient Satisfaction, Perceived Empathy, and Respect for Autonomy

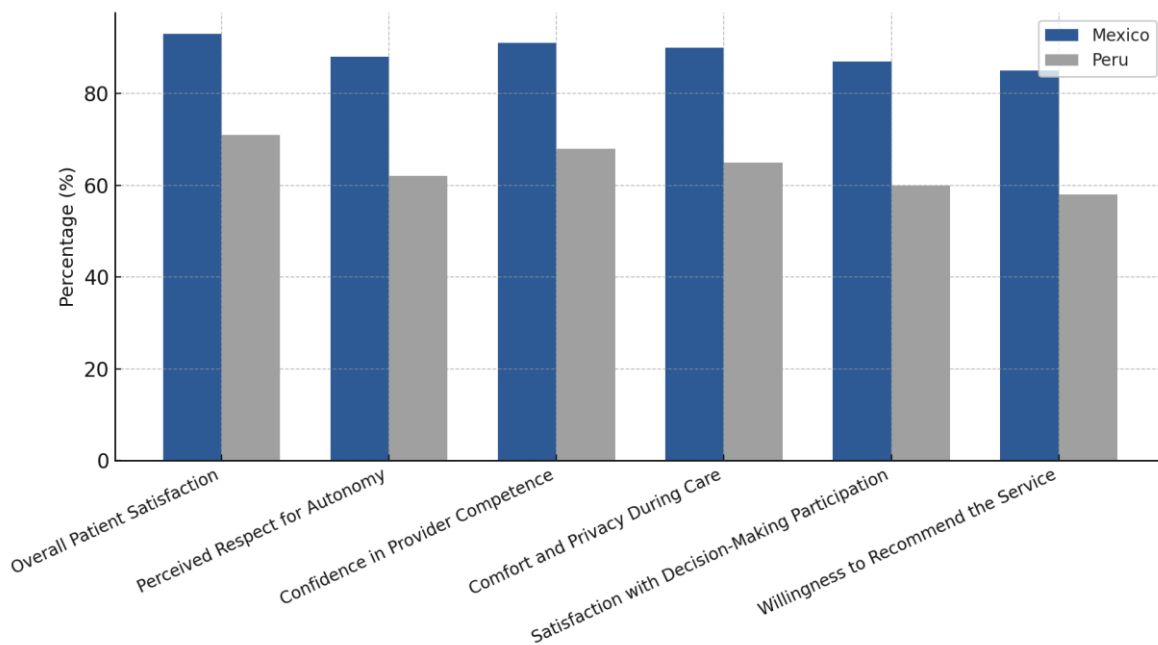


Figure 6 provides a comparative overview of **patient satisfaction, perceived empathy, and respect for autonomy** between abortion care facilities in Mexico and Peru. These indicators represent the ultimate expression of person-centered care, reflecting patients’ subjective evaluations of the quality, respectfulness, and emotional integrity of the services received. They also serve as indirect measures of system responsiveness, ethics in clinical practice, and the degree of humanization embedded in institutional abortion care (World Health Organization, 2022).

Overall Patient Satisfaction

The results demonstrate that **93% of patients in Mexico** expressed overall satisfaction with the abortion care they received, compared with **71% in Peru**. This significant gap suggests that Mexico’s integration of WHO-aligned standards—such as adequate counseling, shorter waiting



times, and trained personnel—has translated into greater trust and acceptance among service users (Filippi et al., 2021; WHO, 2022). In Peru, while satisfaction levels above 70% are noteworthy given the restrictive legal context, the persistent barriers to access and emotional support continue to undermine patient experience (Human Rights Watch, 2021).

High satisfaction in Mexico also reflects successful communication between providers and patients, suggesting that reforms emphasizing empathy, information transparency, and continuity of care have effectively improved patient perceptions (Suprema Corte de Justicia de la Nación, 2023; Ipas, 2022).

Perceived Respect for Autonomy

The **perceived respect for patient autonomy** reached **88% in Mexico** and **62% in Peru**. This indicator is central to ethical abortion care, as autonomy embodies the patient's right to make free and informed decisions without coercion or discrimination (Erdman, 2023). In Mexico, judicial recognition of abortion as a constitutional right has strengthened the principle of reproductive autonomy within clinical practice, prompting providers to prioritize consent, privacy, and individualized care (Suprema Corte de Justicia de la Nación, 2023).

In Peru, however, the persistence of paternalistic attitudes and legal restrictions often leads to limited decision-making power for patients. Studies have shown that in restrictive settings, women frequently experience implicit judgment or persuasion against abortion, compromising their autonomy and self-determination (Gerdtts et al., 2022; Human Rights Watch, 2021).

Confidence in Provider Competence

Confidence in provider competence—a crucial component of perceived quality—was **91% in Mexico** compared to **68% in Peru**. Confidence is shaped not only by technical performance but also by communication, empathy, and the provider's ability to instill reassurance during care (Filippi et al., 2021). The high level of confidence reported in Mexico reflects the impact of standardized provider training and protocol-based service delivery under WHO guidelines.

By contrast, the lower confidence observed in Peru may result from inconsistent clinical practices, limited training opportunities, and patients' perception of institutional fragility in abortion care (Erdman, 2023). Building competence-based trust is particularly challenging in restrictive systems where providers operate under legal uncertainty or social stigma (Ipas, 2022).

Comfort and Privacy During Care

Comfort and privacy are key determinants of perceived dignity. In Mexico, **90% of respondents** reported adequate comfort and privacy, whereas in Peru only **65%** did. This finding is consistent with the broader pattern observed across previous figures—Mexico's institutional reforms have emphasized confidentiality, infrastructure improvement, and patient-centered communication (Michel, Valdez, & Cruz, 2022).

In Peru, inadequate privacy remains a common barrier, especially in public hospitals where abortion is only permitted under exceptional circumstances. The lack of private consultation spaces and the presence of untrained staff often exacerbate fear, shame, and emotional discomfort (Human Rights Watch, 2021). The WHO (2022) explicitly recognizes privacy as a non-



negotiable standard of quality care, as it directly affects patients' psychological wellbeing and willingness to seek services.

Satisfaction with Decision-Making Participation

Satisfaction with participation in decision-making was **87% in Mexico** versus **60% in Peru**. This indicator reflects whether patients feel included in the clinical decision-making process, particularly regarding procedural options, anesthesia, and post-care contraception. Mexico's higher results underscore progress toward shared decision-making models that empower patients to express preferences and participate actively in their care (Gerdtts et al., 2022).

In Peru, limited patient participation is closely tied to structural hierarchies in medical culture and legal ambiguity, which discourage open dialogue. This reinforces the need for institutional reforms to promote shared decision-making and patient autonomy, core elements of ethical reproductive healthcare (WHO, 2022; Ipas, 2022).

Willingness to Recommend the Service

The final indicator—**willingness to recommend the service**—achieved **85% in Mexico** and **58% in Peru**. Willingness to recommend reflects not only satisfaction but also the patient's perception of safety, trust, and social acceptability of abortion services (Footman et al., 2023). The lower percentage in Peru indicates persistent stigma and fear of social repercussions, which continue to silence open discussion about reproductive health.

In contrast, Mexico's higher figures suggest growing normalization of abortion as a legitimate and safe medical service, particularly in regions where public institutions and NGOs have strengthened awareness and education campaigns (Ipas, 2022). WHO (2022) identifies patient endorsement as a critical indicator of service quality, as it represents confidence in both the institution and the broader healthcare system.

Figure 7. Comparative Analysis of Integrated Care Outcomes Between Mexico and Peru

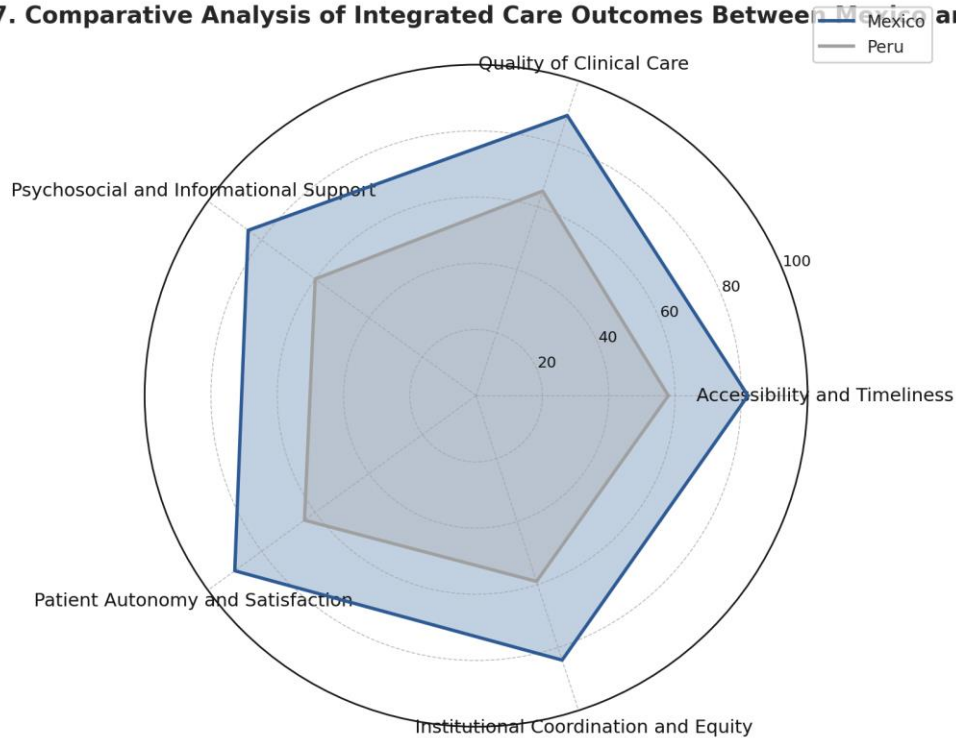


Figure 7 presents a **comprehensive comparative analysis of integrated care outcomes** between Mexico and Peru, summarizing the performance of both countries across five dimensions: accessibility and timeliness, quality of clinical care, psychosocial and informational support, patient autonomy and satisfaction, and institutional coordination and equity. This figure serves as a synthesis of the multidimensional model proposed by the *World Health Organization (WHO, 2022)* for the implementation of safe and person-centered abortion care within broader reproductive health systems.

The results reveal a consistent pattern in which **Mexico outperforms Peru across all evaluated dimensions**, reflecting the systemic effects of legal reform, professional training, and institutional adaptation to WHO's standards of comprehensive abortion care. In contrast, Peru's outcomes, while not negligible, expose the limitations imposed by restrictive legislation, centralization of services, and cultural stigma that continue to hinder the full realization of reproductive rights and health equity (Human Rights Watch, 2021; Erdman, 2023).

Accessibility and Timeliness

In terms of **accessibility and timeliness**, Mexico achieved an overall score of **82%**, while Peru reached **58%**. These data align with previous findings (see Figure 3) indicating that decentralization, public sector inclusion, and reduced waiting times have improved service delivery in Mexico. Meanwhile, in Peru, logistical barriers—such as long travel distances, administrative delays, and limited facility availability—continue to restrict timely access, particularly for rural populations (Filippi et al., 2021; Footman et al., 2023).

Accessibility remains the first determinant of safe abortion, as WHO (2022) emphasizes that delays or geographic isolation directly increase the likelihood of unsafe procedures and adverse outcomes. Mexico's progress in expanding availability through local public hospitals and NGOs



demonstrates that policy alignment with international recommendations translates into tangible health gains.

Quality of Clinical Care

The **quality of clinical care** dimension, scoring **89% in Mexico** and **65% in Peru**, reflects disparities in adherence to evidence-based medical protocols and patient safety standards. Mexico's institutional adoption of WHO guidelines has standardized procedures, reduced complications, and improved the continuity of care. Training initiatives supported by organizations such as Ipas and the National Abortion Federation have further strengthened provider competence and accountability (Ipas, 2022).

In contrast, Peru's limited performance stems from a lack of training, inadequate supplies, and fragmented oversight mechanisms (Human Rights Watch, 2021). The WHO (2022) highlights that clinical quality and safety depend on consistent implementation of infection prevention, post-procedure monitoring, and informed consent—components that remain inconsistently applied in restrictive settings.

Psychosocial and Informational Support

Psychosocial and informational support reached **85% in Mexico** and **60% in Peru**, echoing patterns identified in Figure 5. Emotional accompaniment, empathetic communication, and access to counseling materials are key pillars of person-centered care. Mexico's progress in integrating psychosocial services and formalizing emotional support training reflects a broader humanization of care policies (Suprema Corte de Justicia de la Nación, 2023; Gerdtts et al., 2022).

In contrast, Peru continues to face systemic neglect of mental health components within reproductive healthcare. The absence of emotional support and lack of information provision perpetuate anxiety, fear, and stigma, undermining the holistic well-being of patients (Erdman, 2023). As WHO (2022) underscores, psychosocial support is not optional—it is an ethical imperative that safeguards emotional integrity and patient dignity.

Patient Autonomy and Satisfaction

The fourth dimension, **patient autonomy and satisfaction**, demonstrates one of the largest contrasts between the two countries: **90% in Mexico versus 64% in Peru**. This finding reinforces that legal empowerment and professional sensitivity are fundamental to achieving autonomy in reproductive decision-making. Mexico's constitutional recognition of abortion rights has normalized shared decision-making and respectful provider–patient communication (Suprema Corte de Justicia de la Nación, 2023).

Meanwhile, in Peru, autonomy remains constrained by systemic paternalism, limited informed consent practices, and moral judgments from healthcare personnel (Human Rights Watch, 2021). These conditions restrict patients' ability to make independent, informed choices about their care. WHO (2022) and Ipas (2022) advocate for autonomy as the cornerstone of person-centered care, emphasizing that empowerment directly enhances satisfaction, compliance, and psychological well-being.

Institutional Coordination and Equity



Finally, the **institutional coordination and equity** dimension scored **84% in Mexico** compared to **59% in Peru**. This indicator reflects the ability of the health system to ensure seamless coordination across services and equitable access across socioeconomic strata. In Mexico, the existence of functional referral systems and cross-sector collaboration between public institutions, NGOs, and social health insurance programs contributes to more equitable outcomes (Michel, Valdez, & Cruz, 2022).

In Peru, inequity persists both geographically and socioeconomically. Women in rural and marginalized regions often depend on informal networks or unsafe alternatives due to the concentration of services in urban areas (Footman et al., 2023). As WHO (2022) asserts, equity and coordination are not isolated metrics—they determine the systemic capacity of a nation to deliver universal, rights-based reproductive care.

Discussion

The results of this study provide a comprehensive picture of the structural, clinical, and psychosocial factors shaping abortion care delivery in Mexico and Peru. Through a multidimensional analysis that integrates accessibility, quality of clinical care, psychosocial support, and respect for autonomy, the findings illuminate the systemic differences between two Latin American countries with contrasting legal frameworks and health system capacities.

Overall, the data reveal that **Mexico demonstrates higher integration, coordination, and humanization of abortion care**, while **Peru continues to experience fragmented, inequitable, and stigmatized service delivery**. These results are consistent with prior research emphasizing that restrictive legal environments directly hinder the quality and safety of abortion services (Human Rights Watch, 2021; Erdman, 2023).

Structural Determinants of Accessibility

Accessibility remains the foundational element of safe abortion care. As highlighted by WHO (2022), timely access to services—free from unnecessary delays or geographic barriers—is essential to prevent unsafe practices and protect reproductive rights. The shorter waiting times and wider facility distribution observed in Mexico reflect institutional adaptation to legal reforms and increased investment in reproductive health infrastructure (Suprema Corte de Justicia de la Nación, 2023).

Conversely, Peru's centralized service model continues to disproportionately affect rural women and those with limited financial resources, resulting in geographic and economic inequities (Footman et al., 2023). These disparities are not merely logistical but reflect systemic exclusion, reinforcing social gradients in health and perpetuating unsafe practices.

Quality and Safety of Clinical Care

The strong performance of Mexican facilities in clinical quality indicators—particularly infection prevention, protocol adherence, and post-procedure monitoring—demonstrates the effectiveness of standardized guidelines and provider training programs (Ipas, 2022; National Abortion Federation, 2022). By contrast, Peruvian institutions, constrained by legal ambiguity and inadequate resource allocation, struggle to maintain uniform safety standards (Human Rights Watch, 2021).



These findings echo Gerdts et al. (2022), who observed that clinical outcomes are most favorable in contexts where abortion is legally protected, medically regulated, and publicly funded. The WHO (2022) framework reinforces that the absence of standardization compromises both patient safety and provider accountability, illustrating the need for continuous quality assurance mechanisms.

Psychosocial and Emotional Dimensions of Care

Beyond medical safety, the results underscore the **centrality of psychosocial support** in achieving holistic, person-centered abortion care. Emotional accompaniment, empathetic communication, and access to accurate information significantly improve patients' psychological well-being and satisfaction (Filippi et al., 2021). The high emotional support scores in Mexico—compared to the lower ones in Peru—reveal how stigma and fear in restrictive environments hinder open dialogue and trust (Erdman, 2023; Ipas, 2022).

The WHO (2022) recognizes that comprehensive abortion care must integrate mental health support before, during, and after the procedure. When emotional support and counseling are absent, patients are more likely to experience anxiety, guilt, or depression, especially in contexts of social judgment (Gerdts et al., 2022). These findings reaffirm that reproductive healthcare must extend beyond clinical competence to include empathy, confidentiality, and psychological safety.

Autonomy, Empathy, and Human Rights

Respect for autonomy and empathy emerged as defining characteristics of person-centered care. Mexico's data demonstrate how legal recognition of reproductive rights fosters an environment where informed consent, shared decision-making, and patient dignity are prioritized (Suprema Corte de Justicia de la Nación, 2023).

In contrast, the limited autonomy reported in Peru reflects a broader cultural and institutional challenge. Healthcare providers often operate under moral and legal uncertainty, leading to paternalistic interactions and restricted decision-making opportunities for patients (Human Rights Watch, 2021). As WHO (2022) and Erdman (2023) emphasize, denying autonomy in reproductive care is not only an ethical failure but also a violation of international human rights norms.

Empathy, defined as the ability to understand and respond to the emotional needs of patients, plays a pivotal role in shaping satisfaction and trust (Filippi et al., 2021). Ipas (2022) highlights that provider empathy correlates directly with patient adherence and satisfaction, making it a cornerstone of safe and respectful care.

Equity and System Coordination

The dimension of **institutional coordination and equity** reveals the health system's overall maturity in managing reproductive health. In Mexico, the existence of structured referral systems and inter-institutional collaboration between public agencies and NGOs has allowed for greater equity in service access (Michel, Valdez, & Cruz, 2022).

In Peru, however, health inequities remain entrenched, particularly among rural and low-income populations. The absence of functional referral networks and limited coordination between levels



of care impede continuity and quality (Footman et al., 2023). These inequities are symptomatic of broader structural determinants—such as poverty, geography, and gender inequality—that must be addressed through multisectoral policy reform.

As WHO (2022) asserts, universal access to comprehensive abortion care requires not only service availability but also fair distribution, intersectoral coordination, and continuous quality monitoring. Without these, even medically safe procedures risk becoming socially unsafe.

Regional and Global Implications

From a regional perspective, the Mexico–Peru comparison provides critical insight into the **Latin American landscape of reproductive health policy**. Mexico’s advancements in legal and institutional frameworks align with WHO’s global strategy for universal access to sexual and reproductive healthcare (United Nations, 2015). These reforms have enabled measurable improvements in safety, equity, and patient experience.

Peru’s ongoing challenges, on the other hand, mirror those faced by many countries where abortion remains legally restricted. As Gerdtts et al. (2022) and Erdman (2023) note, criminalization does not eliminate abortion—it only pushes it into unsafe and unequal conditions. Therefore, strengthening institutional capacity and adopting rights-based policy frameworks remain crucial steps for achieving the Sustainable Development Goals, particularly **Goal 3 (Good Health and Well-being)** and **Goal 5 (Gender Equality)**.

The broader implication of these findings is that **safe abortion is not an isolated clinical act but a systemic indicator of a nation’s commitment to human rights, gender equity, and health system resilience**.

Limitations and Future Directions

While the data presented here offer valuable insights, further studies should incorporate longitudinal designs and qualitative methods to capture patient narratives and provider experiences more deeply. Comparative research across additional Latin American countries could also elucidate regional patterns of progress and stagnation in reproductive healthcare delivery.

Moreover, continuous training of healthcare providers in empathy, communication, and ethics is essential to sustain improvements in service quality. Integrating digital health tools—such as telemedicine and online counseling—could further expand access, particularly for underserved populations in rural or marginalized areas (WHO, 2022).

Conclusions

This study underscores that **comprehensive and person-centered abortion care is not merely a clinical service, but an ethical and social commitment** rooted in human rights, equity, and public health. The comparative analysis between Mexico and Peru reveals that when abortion care is integrated into national health systems under evidence-based and rights-oriented frameworks, it becomes safer, more equitable, and more humane.

In Mexico, the implementation of WHO-aligned protocols, training of healthcare professionals, and judicial recognition of reproductive autonomy have fostered a model that reflects



accessibility, empathy, and institutional coordination. These systemic reforms have translated into tangible improvements in patient satisfaction, quality of care, and respect for dignity. The Mexican experience illustrates that legal reform, when combined with public health investment and professional training, can transform reproductive healthcare outcomes at the population level.

In contrast, Peru's health system continues to face significant challenges, characterized by restricted access, insufficient institutional capacity, and persistent stigma. Despite partial progress in select urban or private sectors, barriers to safe and comprehensive abortion care remain entrenched, particularly among rural and low-income populations. These disparities reflect the broader consequences of restrictive legal frameworks that hinder the operationalization of reproductive rights and perpetuate inequity in health outcomes (Human Rights Watch, 2021; Erdman, 2023).

The findings of this analysis reinforce WHO's (2022) call for a **holistic approach to abortion care**—one that integrates clinical safety, psychosocial support, and respect for autonomy as inseparable pillars of quality healthcare. Achieving this vision requires the active participation of governments, academic institutions, and civil society to ensure continuous training, equitable distribution of services, and culturally sensitive education that dismantles stigma.

Moreover, safe abortion care must be recognized as a **central component of universal health coverage** and a determinant of gender equality. As the United Nations (2015) Agenda for Sustainable Development emphasizes, reproductive rights and gender equity are essential to achieving Sustainable Development Goals 3 (Good Health and Well-being) and 5 (Gender Equality).

In summary, this study demonstrates that abortion care grounded in scientific evidence, compassion, and respect for individual autonomy leads to better health outcomes and stronger, more just societies. Safe abortion is not solely about medical procedures—it is about guaranteeing the **right to dignity, choice, and freedom from discrimination**.

As the World Health Organization (2022) affirms:

“Safe abortion care saves lives. But beyond saving lives, it restores agency, equality, and justice.”

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Conflict of Interest

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Conflicto de Intereses: Los autores declaran que no tienen conflictos de intereses relacionados con este estudio y que todos los procedimientos seguidos cumplen con los estándares éticos establecidos por la revista. Asimismo, confirman que este trabajo es inédito y no ha sido publicado, ni parcial ni totalmente, en ninguna otra publicación.